PRINTED: 05/13/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155064 04/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3518 SOUTH LAFOUNTAIN STREET FAIRMONT REHABILITATION CENTER, LLC KOKOMO, IN46902 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0000 By submitting the enclosed F0000 This visit was for the Investigation of information we are not admitting Complaint IN00089695. the truth or accuracy of any specific findings or allegations. Complaint IN00089695- Substantiated, We reserve the right to contest the findings or allegations as part federal/state deficiencies related to the of any proceedings and submit allegation are cited at F225 and F226. these responses pursuant to our regulatory obligations. The facility Survey date: April 27. 28, 2011 requests the Plan of Correction be considered our allegation of compliance to the state findings Facility number: 000025 of the complaint survey Provider number: 155064 conducted on April 27 and 28, AIM number: 100274850 2011. The faiclity is requesting a DESK REVIEW as there was not any actual harm identifded during Surveyor: Jeri Curtis, RN this survey. Census bed type: SNF: 13 SNF/NF: 45 Total: 58 Census payor type: Medicare: 13 39 Medicaid: Other: 6 58 Total: Sample: 4

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

findings cited in accordance with 410 IAC

These deficiencies also reflect state

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

16.2

D87Q11

Facility ID:

000025

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064			(X2) MULTIPLE  A. BUILDING  B. WING	CONSTRUCTION  00	(X3) DATE S COMPLI 04/28/20	ETED
	PROVIDER OR SUPPLIER		3518	T ADDRESS, CITY, STATE, ZIP CODE SOUTH LAFOUNTAIN STREET DMO, IN46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
	Quality review c by Bev Faulkner	ompleted on May 3, 2011 , RN				
F0225 SS=D	have been found gor mistreating resinave had a finding nurse aide registry mistreatment of resoftheir property; a has of actions by a employee, which was ervice as a nurse the State nurse aid authorities.	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or gentered into the State v concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for eaide or other facility staff to de registry or licensing				
	abuse, including ir and misappropriat reported immediat the facility and to o with State law thro	njuries of unknown source ion of resident property are rely to the administrator of other officials in accordance ough established procedures tate survey and certification				
	alleged violations	ave evidence that all are thoroughly investigated, further potential abuse while in progress.				
	reported to the ad representative and accordance with S State survey and o working days of the	nvestigations must be ministrator or his designated if to other officials in state law (including to the certification agency) within 5 is incident, and if the alleged appropriate corrective sen.				
	Based on	record review	F0225	Corrective Action: Resident D have been assessed. The		05/06/2011

000025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155064 04/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3518 SOUTH LAFOUNTAIN STREET FAIRMONT REHABILITATION CENTER, LLC KOKOMO, IN46902 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE have not suffered no physical or and interview, the psychological effects from the alleged events that occured. All facility failed to ensure allaegations of abuse are being immediately reported to the allegations of abuse, administrator and a member of administration is notifyiing the involving 2 residents Indiana State Department of Health in accordance with the (Residents C and D) reporatble events quidelines.Identification: All among the sample of 4, allegations are being immediately reported to administration. The reviewed for abuse, were facility has adopted the practice upon receiving an allegation of reported to the state abuse the report will be faxed to the Indiana State Department of survey agency and other Health in acordance with the reportable events guidelines and officials in accordance the confirmation of receipt of this report will be obtained and placed with state law. in the file with the investigation of the alleged event. System The facility also failed to Change: A mandatory in-service was provided for staff related to report the results of the the facility abuse policy. In addition the facility has adopted investigations within 5 the practice of printing out the confirmation of thereceipt of this working days to the state report and placing it with the investigation. Monitoring: survey agency and other Following any allegation of abuse the interdisciplinary team will officials in accordance meet to review the alledged event. The team will validate that all steps of the facility abuse with state law. policy have been followed in accordance with the reportable events guidelines. The facility will conduct audits weekly for 3 Findings include: weeks, monthly for 3 months and quarterly for 3 quarters All

NAME OF PR FAIRMON  (X4) ID PREFIX		IDENTIFICATION NUMBER: 155064	A. BUIL B. WING	DING	00	COMPLETED
FAIRMON  (X4) ID  PREFIX	OVIDER OR SUPPLIER	155064		3	<del>-</del>	04/28/2011
(X4) ID PREFIX	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
PREFIX	T REHABILITATIO	N CENTER, LLC			OUTH LAFOUNTAIN STREET 10, IN46902	
	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
	1. Durin 4:20 P.M., Administr the facility had two al abuse. The indicated t involving residents, (Residents been inves internally substantia The Adminindicated t allegations substantia	g a 4/27/11, , interview, the ator indicated had recently legations of Administrator the allegations, two different  C and D), had stigated and were not ted. nistrator because the swere not ted, a report ade to the state		TAG	identified trends will be revier at the monthly Clinical meeting any continued issues will be brought to QAA committee for further recommendations and resolutions. The QAA committee may discontinue any further monitoring if no trend identified.	wed ng. e or any d/ or iittee

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M A. BUI		INSTRUCTION 00	(X3) DATE S COMPLE		
		155064	B. WIN	G		04/28/20	)11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET		
FAIRMOI	NT REHABILITATIO	N CENTER, LLC		1	10, IN46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Indiana St	tate					
	Departme	nt of Health.					
	The Admi	nistrator					
		Resident (C)					
	had allege	ed rape.					
	The Admi	nistrator					
	indicated	the second					
	allegation	was the					
	refusal of	a certified					
	nursing as	ssistant					
	( CNA#1)	to provide					
	personal c	eare to Resident					
	(D). The <i>A</i>	Administrator					
	indicated	CNA#1 was					
	suspended	during the					
	internal in	vestigation.					
	The Admi	nistrator					
	provided of	copies of both					
	internal in	vestigations.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		A. BUI	LDING	NSTRUCTION  00	(X3) DATE S COMPL 04/28/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	3518 S0	ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET		
	NT REHABILITATIO			ļ	//O, IN46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	The 4/15/	11, allegation					
	of rape by Resident (C)						
	was repor	ted by the					
	evening su	upervisor,					
	Registered	d Nurse					
	(RN#1).						
	The written statement of						
	RN #1 inc	licated after					
	having red	ceived the					
	allegation	she (RN#1)					
	found Res	sident (C) in					
	the dining	room, crying,					
	while she	spoke with a					
	family me	ember (#1).					
	RN #1 do	cumented she					
	escorted (	Resident C) to					
	her room.	Resident (C)					
	said she d	id not know					
	what happ	ened, she was					
	asleep in b	ped, got up and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064			LDING	NSTRUCTION  00	(X3) DATE COMP 04/28/2	LETED	
	PROVIDER OR SUPPLIER		1	3518 S0	ADDRESS, CITY, STATE, ZIP CODE DUTH LAFOUNTAIN STREE MO, IN46902	T	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
	changed h	er clothes, and					
	felt funny.						
	Resident (	(C) related she					
	always ke	pt herself					
	clean, how	vever, noticed					
	a smell.						
	Resident (C) also said it						
	was as if s	someone had					
	touched h	er, "he could					
	have rape	d me."					
	RN #1 do	cumented					
	earlier in t	the evening,					
	CNA #2 h	ad found					
	Resident (	(C) in a male					
	resident's	room with her					
	pants off a	and the blouse					
	half remove	ved. CNA #2					
	reported o	ne of the male					
	residents	was not in the					
	room and	the other was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 04/28/2011	
	PROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREE MO, IN46902	Т
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	outside an	nd would not			
	enter beca	use he saw			
	Resident (	(C).			
	Later, it w	as discovered,			
	the same	evening			
	Resident (	(C) had also			
	reported to	o Qualified			
	Medicatio	on Aide			
	(QMA#1)	, when she			
	woke up s	someone had			
	raped her.	QMA#1 asked			
	if Residen	t (C) had seen			
	the persor	n. Resident (C)			
	had said,	no because she			
	was aslee	p. QMA #1			
	called a fa	mily member			
	(#2) to co	me be with			
	Resident (	(C).			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155064	A. BUI B. WIN	LDING IG		04/28/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
FAIRMOI	NT REHABILITATIO	N CENTER, LLC			10, IN46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COME	(X5) PLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		ATE
	RN #1 no						
	Social Ser	vices Director					
	(SSD), wh	no came to the					
	facility an	d interviewed					
	Resident (	(C) in the					
	presence of	of a family					
	member (	#2). The SSD					
	asked fam	nily member #2					
	if he felt I	Resident (C)					
	had been	raped. Family					
	member #	2 replied in the					
	past medi	cations or a					
	urinary tra	act infection					
	had cause	d inappropriate					
	behaviors	•					
	Family m	ember #2					
	indicated	he did not					
	believe ra	pe had					
	occurred and thought						
	Resident (	•					
		(-)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		INSTRUCTION 00	(X3) DATE S COMPL		
		155064	B. WIN	G		04/28/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET		
	NT REHABILITATIO			L	1O, IN46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		something that					
	<b>.</b>	ay not have					
	occurred i	n her past.					
	Family me	ember #2					
	indicated	he did want the					
	physician	notified.					
	The SSD	documented he					
	obtained s	statements from					
	all witness	ses and					
	contacted	the					
	Administr	ator by					
	telephone	. The					
	investigati	ion concluded					
	Resident (	(C) had been					
	increasing	confusion and					
	delusions	and had					
	confused a	another room					
	with her o	wn. The SSD					
	documented after						
	interviews	s with all					

000025

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155064			ULTIPLE CO LDING	NSTRUCTION 00	COMPL	ETED	
		155064	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	04/28/2	011
NAME OF F	PROVIDER OR SUPPLIER				OUTH LAFOUNTAIN STREET		
	NT REHABILITATIO				ЛО, IN46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	ME	DATE
	involved h	ne concluded					
	Resident (						
	experience	e actual harm					
	and the ev	ent had not					
	occurred.	Documentation					
	indicated ?	Resident (C)					
	exhibited	no signs of					
	distress du	aring interview					
	and had di	iagnosis of					
	dementia.						
	The 4/15/	11, Abuse,					
	Neglect, E	Exploitation					
	Investigat	ing Checklist,					
	completed	l by the					
	Administr	rator, was					
	included v	with the					
	internal in	vestigation.					
	The check	dist had 15					
	points, inc	cluding					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		(X2) MULTIP  A. BUILDING  B. WING		nstruction 00	(X3) DATE : COMPL <b>04/28/2</b>	ETED		
	PROVIDER OR SUPPLIER		STI 35	STREET ADDRESS, CITY, STATE, ZIP CODE  3518 SOUTH LAFOUNTAIN STREET  KOKOMO, IN46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	obtaining	an incident						
	report of t	he allegation,						
	obtaining	written						
	statements	s from all						
	involved,	notifying the						
	family and	d physician,						
	obtaining	a report from						
	the Medic	al Director,						
	reviewing	CNA						
	assignmer	nt sheets for						
	appropriat	te wing and						
	shift, and	if an employee						
	was invol	ved, obtaining						
	copies of	any previous						
	suspected	abuse reports.						
	Point #4, 1	reporting to the						
	Ombudsm	nan, state						
	survey ago	ency, and						
	police, wa	s checked as						
	no, with a	hand written						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE S COMPL		
		155064	A. BUII B. WIN			04/28/2	011
NAME OF F	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET		
FAIRMOI	NT REHABILITATIO	N CENTER, LLC		1	MO, IN46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	comment,	"no abuse."					
	RN #1 wa	s interviewed					
	at 4:00 P.1	M., 4/28/11,					
	and indica	ited the					
	allegation	of Resident					
	(C) had od	ccurred during					
	her first w	reek of					
	employme	ent. RN #1					
	indicated	she had					
	followed t	the outlined					
	procedure	and had					
	contacted	the SSD to					
	interview	and had					
	notified th	ie					
	Administr	ator					
	immediate	ely.					
		-					
	The record	d of Resident					
	(C) was re	eviewed at					
	,						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155064	A. BUII B. WIN		<u> </u>	04/28/2	011
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE  OUTH LAFOUNTAIN STREET		
FAIRMON	NT REHABILITATIO	N CENTER, LLC			1O, IN46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE .	DATE
	12:40 P.M	I., 4/28/11, and					
	indicated a	a $5/09$ ,					
	admission	, with					
	diagnoses	, including, but					
	not limited	d to, dementia.					
	Resident (	(C) was					
	assessed a	s having					
	moderate	impairment					
	and a shor	t term memory					
	loss of the	4/16/11,					
	annual Mi	nimum Data					
	Set (MDS	).					
	An intervi	ew with					
	Resident (	(C) was					
	attempted	at 1:10 P.M.,					
	4/28/1. R	esident (C) did					
	not have r	ecall of the					
	alleged in	cident.					
	2. The in	ternal					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		A. BUI	LDING	ONSTRUCTION  00	(X3) DATE S COMPL 04/28/20	ETED	
NAME OF P	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	04/20/2	011
FAIRMO	NT REHABILITATIO	N CENTER, LLC		1	OUTH LAFOUNTAIN STREET MO, IN46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	investigat	ion of the					
	4/20/11, a	llegation of					
	Resident (	D) indicated a					
	request to	CNA #1 to					
	assist in c	hanging a					
	brief. Res	ident (D)					
	alleged Cl	NA#1 had said					
	(Resident	D) could "do it					
	herself."						
	The invest	tigation was					
	titled Alle	gation of					
	Abuse, 4/2	21/11, Resident					
	(D).						
	The 4/20/	,					
	document	ed interview of					
	Resident (	(D) by the SSD					
	indicated	she (Resident					
	D) had red	quested CNA					
	#1 to assis	st with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMP 04/28/2	LETED	
	PROVIDER OR SUPPLIER			3518 S0	ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREE MO, IN46902	T	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	changing	a brief, was					
	refused, cl	hanged herself,					
	did not ha	ve dry pants,					
	and remai	ned only in the					
	dry brief t	he rest of the					
	night.						
	Document	tation indicated					
	after ques	tioning by the					
	Director o	of Nursing					
	(DoN), an	d the SSD,					
	Resident (	(D) stated she					
	did not ne	ed help with					
	changing	a brief, she had					
	wanted Cl	NA #1 to do it					
	because it	was her job to					
	help.						
	The 4/21/	11, conclusion,					
	document	ed by the SSD,					
	indicated	after interviews					
	with all in	volved, it was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155064	B. WIN	IG		04/28/20	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET		
FAIRMOI	NT REHABILITATIO	N CENTER, LLC		KOKON	/IO, IN46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	determine	d Resident (D)					
	had not m	ade a					
	complaint	to the nurse on					
	duty on 4/	20/11. The					
	conclusion	n also indicated					
	Resident (	D) had made a					
	comment	to another					
	CNA (not	identified) she					
	had sat in	wet pants until					
	the midnig	ght shift had					
	assisted he	er.					
	Document	tation indicated					
	the midnig	ght shift nurse					
	and CNA	(unidentified)					
	had said R	Resident (D)					
	was dry w	then they came					
	on duty.						
	The final	documented					
	conclusion	n was the					
	admission	of Resident					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155064			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE : COMPL	ETED
		100004	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	04/28/2	UII
	PROVIDER OR SUPPLIER			3518 S0	OUTH LAFOUNTAIN STREET		
	NT REHABILITATIO	·		L	1O, IN46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	` /	as capable of					
	changing	her brief and					
	had reque	sted CNA #1					
	do so beca	ause she					
	(Resident	D) wanted her					
	to assist w	ith the change.					
	The 4/20/	11, Abuse,					
	Neglect, E	Exploitation					
	Investigat	ing Checklist,					
	completed	l by the					
	Administr	ator, was					
	included v	with the					
	internal in	vestigation.					
	On point #	44, report made					
	to the Om	budsman, and					
	state surve	ey agency, The					
	Administr	ator indicated					
	no, with a	written					
	comment,	"no abuse."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155064		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE COMPI 04/28/2	LETED	
	PROVIDER OR SUPPLIER			3518 S0	ODDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET O, IN46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	The record (D) was reported to the pression and a hister Resident (assessed of the pression assessed of the pression and a hister Resident (assessed of the pression assessed of the pression and a hister Resident (assessed of the pression and a histor Resident (assessed	d of Resident eviewed at 3:15 8/11, and a 3/30/11, s, included, but imited to, n, chronic pain, ory of falls.  (C) was on the 4/6/11,			CROSS-REFERENCED TO THE APPROPR	ATE	l l
	Set (MDS cognitivel An attempt was made	y alert. of to interview at 4:40 P.M., nd Resident					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155064	A. BUILDING B. WING		04/28/2011
NAME OF F	PROVIDER OR SUPPLIER		I .	ET ADDRESS, CITY, STATE, ZIP CODE	
FAIRMOI	NT REHABILITATIO	N CENTER, LLC	- 1	SOUTH LAFOUNTAIN STREET OMO, IN46902	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
	This feder	ral tag relates to			
		t IN00089695.			
	_				
	3.1-28(c)				
	3.1-28(e)				
F0226 SS=D	written policies and mistreatment, neg	levelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property.			
	Based on	record review	F0226	Corrective Action: Residente Cand D have suffered no no	ill 03/00/2011
	and interv	iew, the		effects related to the failure report the allegations. In	iO
	facility fai	iled to		therevent that any further allegationsoccur they will be	
	implemen	t established		reported to adminstration an Indiana State Department of	f
	policies fo	or reporting		Health in accordance with the facility policy. Identification:	
	alleged ab	ouse of 2		allegation of abuse will be immediately reported to	
	residents (	(Residents C		administration who in turn w notify the Indiana State	ill
	and D) an			Department of Health in accordance with the ereport	
	sample of	4, reviewed		events guidelines. A confirm of the receipt of this report w	I
	for abuse.			printed and placed in investigationfile. Any emplo	yee
	Findings i	nclude:		who fails to follow the facility abuse policy will be s to the facilitiesdisciplinarty process whuich may include termination of employment. System Change mandatory in-service was	,

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155064	1	LDING	00	04/28/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	OUTH LAFOUNTAIN STREET		
FAIRMOI	NT REHABILITATIO	N CENTER, LLC		KOKON	лО, IN46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	DATE
	The facility's policy,				provided for employees related to the facility abuse policy. The		
	Resident A	Abuse			staff was advised that failure follow the facility abuse polic		
	Prevention	n (undated)			result in disciplinary action w may include termination of		
	was provi	ded by the			employment. In addition the facility has adopted the pract	tice	
	Director o	of Nursing,			of printing out confirmation o receipt of this report to the Indiana Statae Deoartment	tne .	
	4/27/11.				of Health and placing that		
	The defini	itions of abuse				huse	
	included v	withholding			Following any allegation of a the interdisciplinary team will review the event. The te		
	care or pri	ivileges, and			will validate that all steps of t facility abuse policy have be	he	
	sexual abu				followed in accordance with reportable events guidelines	the	
	The facilit	•			facility will conduct audits we for 3 weeks, monthly for 3 weeks.	ekly	
		ory statement			and quarterly for 3 quarters any idetified trends will be		
		an intent to			reviewed at our monthly Clin meeting. any identified issue		
	•	nd protect the			be referred to the QAA committee. The QAA comm	ittee	
		each resident			may discontinue any further monitoring if no trrends are		
		truct all staff			identified.		
	-	ance with all					
	applicable policies and						
	procedures.						
	Point E, #	2,					

000025

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		<b>P</b> . WIIV	3518 S0	ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET MO, IN46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	reporting/	response,					
	under guio	delines					
	indicated	the					
	Administr	rator was to					
	take appro	opriate actions					
	following	the completion					
	of an inve	stigation and					
	the prepar	ration of a					
	written rej	port and					
	statements	s. Such actions					
	were to in	clude, but not					
	be limited	to, notification					
	of state ag	gency, resident					
	and family	y members,					
	attending	physician and					
	the Medic	al Director.					
	Point E, #	5 indicated the					
	Administr	rator was					
	responsibl	le to ensure all					
	alleged vi	olations and all					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		A. BUI	LDING	ONSTRUCTION  00	(X3) DATE S COMPL 04/28/2	ETED	
		100004	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	04/20/2	011
	PROVIDER OR SUPPLIER			3518 S	OUTH LAFOUNTAIN STREET		
	NT REHABILITATIO	·		L	лО, IN46902		(115)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ted incidents					
	were repo	rted to the					
	applicable	state agencies					
	in accorda	nce with					
	regulation	S.					
	1. Durin	g a 4/27/11,					
	4:20 P.M.	, interview, the					
	Administr	ator indicated					
	the facility	y had recently					
	had two al	llegations of					
	abuse. The	e Administrator					
	indicated 1	the allegations,					
	involving	2 different					
	residents,						
	(Residents	s C and D), had					
	been inves	stigated					
	internally	and were not					
	substantia	ted.					
	The Admi	nistrator					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064			LDING	NSTRUCTION 00	(X3) DATE COMPI 04/28/2	LETED	
	PROVIDER OR SUPPLIER		1	3518 S0	ODDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET MO, IN46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	indicated	because the					
	allegation	s were not					
	substantia	ted, a report					
	was not m	ade to the state					
	survey ago	ency, the					
	Indiana St	rate					
	Departme	nt of Health.					
	The Admi	nistrator					
	indicated	Resident (C)					
	had allege	d rape.					
	The Admi	nistrator					
	indicated	the second					
	allegation	was the					
	refusal of	a certified					
	nursing as	sistant					
	( CNA#1)	to provide					
	personal c	are to Resident					
	(D). The A	Administrator					
	indicated	CNA#1 was					
	suspended	l during the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155064		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPI 04/28/2	LETED	
	PROVIDER OR SUPPLIER			3518 S	ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET MO, IN46902	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	internal in	vestigation.					
	The Admi	nistrator					
	provided of	copies of both					
	internal in	vestigations.					
	The 4/15/	11, allegation					
	of rape by	Resident (C)					
	was repor	ted by the					
	evening su	apervisor,					
	Registered	d Nurse					
	(RN#1).						
	The writte	en statement of					
	RN #1 inc	licated after					
	having rec	ceived the					
	allegation	she (RN#1)					
	found Res	sident (C) in					
	the dining	room, crying,					
	while she	spoke with a					
		ember (#1).					
	_	cumented she					

Facility ID:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155064		LDING	NSTRUCTION  00	(X3) DATE S COMPL 04/28/2	ETED	
	PROVIDER OR SUPPLIER NT REHABILITATIO		3518 S0	ADDRESS, CITY, STATE, ZIP CODE DUTH LAFOUNTAIN STREET 10, IN46902	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	escorted (	Resident C) to				
	her room.	Resident (C)				
	said she d	id not know				
	what happ	ened, she was				
	asleep in b	oed, got up and				
	changed h	er clothes, and				
	felt funny					
	Resident (	(C) related she				
	always ke	pt herself				
	clean, hov	vever, noticed				
	a smell.					
	Resident (	(C) also said it				
	was as if s	someone had				
	touched h	er, "he could				
	have rape	d me."				
	RN #1 do	cumented				
	earlier in t	the evening,				
	CNN #2 h	ad found				
	Resident (	(C) in a male				
	resident's	room with her				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		- 1		00	COMPL 04/28/2	
COVIDER OR SUPPLIER		· ·	3518 S	OUTH LAFOUNTAIN STREET	•	
(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
pants off a	and the blouse					
half remov	ved. CNA #2					
reported o	ne of the male					
residents v	was not in the					
room and	the other was					
outside an	d would not					
enter beca	use he saw					
Resident (	C).					
Later, it w	as discovered,					
the same e	evening					
Resident (	C) had also					
reported to	o Qualified					
Medicatio	n Aide					
(QMA#1)	, when she					
woke up s	omeone had					
raped her.	QMA#1 asked					
if Residen	t (C) had seen					
the person	. Resident (C)					
had said, r	no because she					
	pants off a half remove reported or residents we room and outside an enter becardent (Later, it we the same experience to Medication (QMA#1) woke up so raped her, if Resident the person	155064	ovider or supplier  T REHABILITATION CENTER, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  pants off and the blouse half removed. CNA #2 reported one of the male residents was not in the room and the other was outside and would not enter because he saw Resident (C).  Later, it was discovered, the same evening Resident (C) had also reported to Qualified Medication Aide (QMA#1), when she woke up someone had raped her. QMA#1 asked if Resident (C) had seen the person. Resident (C)	TREHABILITATION CENTER, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  pants off and the blouse half removed. CNA #2 reported one of the male residents was not in the room and the other was outside and would not enter because he saw  Resident (C).  Later, it was discovered, the same evening  Resident (C) had also reported to Qualified  Medication Aide (QMA#1), when she woke up someone had raped her. QMA#1 asked if Resident (C) had seen the person. Resident (C)	Interpretation of the male residents was not in the room and the other was outside and would not enter because he saw Resident (C).  Later, it was discovered, the same evening Resident (C) had also reported to Qualified Medication Aide (QMA#1), when she woke up someone had raped her. QMA#1 asked if Resident (C) had seen the person. Resident (C)	155064   N BUILDING   N WING   O4/28/2

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		A. BUI	LDING	ONSTRUCTION  00	(X3) DATE S COMPLE 04/28/20	ETED	
	PROVIDER OR SUPPLIER		B. WIN	3518 S0	ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET		
	NT REHABILITATIO			<u> </u>	лО, IN46902		(115)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	was asleep	o. QMA #1					
	called a fa	mily member					
	(#2) to con	me be with					
	Resident (	(C).					
	RN #1 no	tified the					
	Social Ser	vices Director					
	(SSD), wh	no came to the					
	facility an	d interviewed					
	Resident (	(C) in the					
	presence of	of a family					
	member (7	#2). The SSD					
	asked fam	ily member #2					
	if he felt F	Resident (C)					
	had been i	raped. Family					
	member #	2 replied in the					
	past medic	cations or a					
	urinary tra	act infection					
	had cause	d inappropriate					
	behaviors	-					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED		
		155064	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	04/28/2011	$\dashv$
NAME OF F	PROVIDER OR SUPPLIER				OUTH LAFOUNTAIN STREET		
	NT REHABILITATIO			ļ	лО, IN46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	4
	Family m	ember #2					
	indicated	he did not					
	believe ra	pe had					
	occurred a	and thought					
	Resident (	(C) was					
	recalling s	something that					
	may or ma	ay not have					
	occurred i	n her past.					
	Family m	ember #2					
	indicated	he did want the					
	physician	notified.					
	The SSD	documented he					
	obtained s	statements from					
	all witness	ses and					
	contacted	the					
	Administr	rator by					
	telephone	. The					
	investigat	ion concluded					
	Resident (C) had been						
	increasing	confusion and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 04/28/2	LETED	
	PROVIDER OR SUPPLIER			3518 S0	ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET MO, IN46902	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	delusions	and had					
	confused	another room					
	with her o	wn. The SSD					
	document	ed after					
	interviews	s with all					
	involved l	ne concluded					
	Resident (	(C) did not					
	experienc	e actual harm					
	and the ev	ent had not					
	occurred.	Documentation					
	indicated	Resident (C)					
	exhibited	no signs of					
	distress du	aring interview					
	and had d	iagnosis of					
	dementia.						
	The 4/15/	11, Abuse,					
	Neglect, F	Exploitation					
	Investigat	ing Checklist,					
	completed	· ·					
	1	-					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	NSTRUCTION 00	COMPL		
		155064	B. WIN			04/28/2	011
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			DUTH LAFOUNTAIN STREET		
FAIRMOI	NT REHABILITATIO	N CENTER, LLC		1	10, IN46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)	_	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	Administr	rator, was					
	included v	with the					
		vestigation.					
	The check	dist had 15					
	points, inc	cluding					
	obtaining	an incident					
	•	the allegation,					
	obtaining	written					
	statements	s from all					
	involved,	notifying the					
	family and	d physician,					
	obtaining	a report from					
	the Medic	al Director,					
	reviewing	CNA					
	assignmen	nt sheets for					
	appropriat	te wing and					
	shift, and	if an employee					
	was invol	ved, obtaining					
	copies of	any previous					
	suspected	abuse reports.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		(X2) MU A. BUIL B. WING	DING	NSTRUCTION  00	(X3) DATE COMPI 04/28/2	LETED	
	PROVIDER OR SUPPLIER			3518 S0	ODDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET 10, IN46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Point #4, 1	reporting to the					
	Ombudsm	nan, state					
	survey ago	ency, and					
	police, wa	is checked as					
	no,with a	hand written					
	comment,	"no abuse."					
	RN #1 wa	s interviewed					
	at 4:00 P.	M., 4/28/11,					
	and indica	ited the					
	allegation	of Resident					
	(C) had od	ecurred during					
	her first w	reek of					
	employme	ent. RN #1					
	indicated	she had					
	followed 1	the outlined					
	procedure	and had					
	contacted	the SSD to					
	interview	and had					
	notified th	ne					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		(X2) MUL' A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE S COMPL <b>04/28/2</b>	ETED	
	PROVIDER OR SUPPLIER		;	3518 SC	DUTH LAFOUNTAIN STREET 10, IN46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Administr	rator					
	immediate	ely.					
	(C) was ref 12:40 P.M indicated admission diagnoses not limited Resident ( assessed a moderate and a shor loss of the annual Mi Set (MDS An intervi-	, with , including, but d to, dementia. (C) was as having impairment et term memory e 4/16/11, inimum Data ). iew with					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE : COMPL		
		155064	A. BUII B. WIN			04/28/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET		
FAIRMO	NT REHABILITATIO	N CENTER, LLC			лО, IN46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE	DATE
	4/28/1. R	esident (C) did					
	not have r	ecall of the					
	alleged in	cident.					
	2. The in	ternal					
	investigati	ion of the					
	4/20/11, a	llegation of					
	Resident (	D) indicated a					
	request to	CNA#1 to					
	assist in cl	hanging a					
	brief. Resi	ident (D)					
	alleged Cl	NA#1 had said					
	(Resident	D) could do it					
	herself.	,					
		tigation was					
	titled Alle	<b>C</b>					
	'	21/11, Resident					
	<b>.</b>						
	(D).						
	The 4/20/	11,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155064	A. BUILDING B. WING		04/28/2011
NAME OF F	PROVIDER OR SUPPLIER		l	ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET	
FAIRMOI	NT REHABILITATIO	N CENTER, LLC	l l	MO, IN46902	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	document	ed interview of			
	Resident (	(D) by the SSD			
	indicated	she (Resident			
	D) had red	quested CNA			
	#1 to assis	st with			
	changing	a brief, was			
	refused, cl	hanged herself,			
	did not ha	ve dry pants,			
	and remai	ned only in the			
	dry brief t	he rest of the			
	night.				
	Document	tation indicated			
	after ques	tioning by the			
	Director o	of Nursing			
	(DoN), an	d the SSD,			
	Resident (	(D) stated she			
	did not ne	ed help with			
	changing	a brief, she had			
	wanted Cl	NA #1 to do it			
	because it	was her job to			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMP 04/28/2	LETED	
	PROVIDER OR SUPPLIER		1	3518 S0	ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREE MO, IN46902	T	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
	help.						
	The 4/21/	11, conclusion,					
	document	ed by the SSD,					
	indicated	after interviews					
	with all in	volved, it was					
	determine	d Resident (D)					
	had not m	ade a					
	complaint	to the nurse on					
	duty on 4/	20/11. The					
	conclusion	n also indicated					
		(D) had made a to another					
		identified) she					
		wet pants until					
		ght shift had					
	assisted h						
		tation indicated					
		ght shift nurse					
	`	(unidentified)					
		Resident (D)					
	mau saiu r						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMP 04/28/2	LETED	
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE DUTH LAFOUNTAIN STREE IO, IN46902	T	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	was dry w	then they came					
	on duty.						
	The final	documented					
	conclusion	n was the					
	admission	of Resident					
	(D) she w	as capable of					
	changing	her brief and					
	had reque	sted CNA #1					
	do so beca	ause she					
	(Resident	D) wanted her					
	to assist w	ith the change.					
	Neglect, E Investigat completed Administr included v internal in	rator, was					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED 04/28/2011	
		155064	B. WIN		ADDRESS CITY STATE OF CORE	04/20/20	711
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET		
	NT REHABILITATIO	·		KOKON	ло, IN46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	to the Om	budsman, and					•
	state surve	ey agency, The					
	Administr	rator indicated					
	no, with a	written					
	comment,	"no abuse."					
	The record	d of Resident					
	(D) was re	eviewed at 3:15					
	P.M., 4/28	8/11, and					
	indicated a	a 3/30/11,					
	admission	l <b>.</b>					
	Diagnoses	s, included, but					
	were not 1	imited to,					
	depression	n, chronic pain,					
	and a histo	ory of falls.					
	Resident (	(C) was					
	assessed c	on the $4/6/11$ ,					
	initial min	nimum data set					
	(MDS) as	cognitively					
	alert.						

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155064		A. BUILDING  B. WING		(x3) DATE SURVEY  COMPLETED  04/28/2011			
NAME OF PROVIDER OR SUPPLIER  FAIRMONT REHABILITATION CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  3518 SOUTH LAFOUNTAIN STREET  KOKOMO, IN46902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	An attempt to interview						
	was made at 4:40 P.M.,						
	4/28/11, and Resident						
	(D) declined.						
	This federal tag relates to						
	Complaint IN00089695.						
	3.1-28(a)						